Transitioning to LTD?
Follow this checklist to keep things on track

Included in this Packet:

- Letter from your employing agency – *Disability Insurance Program (DIP) Transition from Short-Term Disability (STD) to Long-Term Disability (LTD).*
    - **Complete and sign** this letter if you wish to escrow your available leave balances
    - **Time Sensitive** – Must be received by your HR Department before LTD begins

- Long Term Disability Booklet

- Correspondence from the Office of Pensions that includes important information regarding continued eligibility for medical, dental and/or vision benefits as an LTD beneficiary through the State of Delaware

- Open Enrollment Booklet

- Minnesota Life Waiver of Premium Information Sheet

- Forms to enroll or refuse medical, dental, vision and or blood bank benefits

    - Office of Pensions Application for Health Care Coverage
        - Complete and sign if you do want medical coverage

    - Office of Pension Health Insurance Coverage REFUSAL
        - Complete and sign if you do not want medical coverage

    - Office of Pensions Dental Application
        - Complete and sign if you do want dental coverage

    - Office of Pensions Dental Insurance Coverage REFUSAL
        - Complete and sign if you do not want dental coverage

    - EyeMed Vision Care Enrollment/Change form
        - Complete and sign if you do want vision coverage

    - Vision Insurance Coverage REFUSAL
        - Complete and sign if you do not want vision coverage

    - Application or Waiver for Membership in the Blood Bank of Delaware Group Plan
        - Complete and sign the top part of the form if you want to enroll in Blood Bank
        - Complete and sign the bottom part of the form if you do not want to enroll in Blood Bank

    - Spousal Coordination of Benefits Policy Form for Pensioners
        - Complete and sign if you cover your spouse

- Adult Dependent Coordination of Benefits Form
  - Complete and sign if you cover an adult child ages 21-26

All completed forms to enroll or refuse medical, dental, vision or blood bank benefits must be mailed to the Office of Pensions as soon as possible *to avoid difficulties with your benefits*.

Please mail them to: Office of Pensions
McArdle Bldg
860 Silver Lake Blvd, Ste 1
Dover, DE 19904-2402

If you have any questions regarding your transition from STD to LTD, please call your HR Department at _____.

If you have any questions regarding your medical, dental, vision or blood bank benefits, please the Office of Pensions at 302-739-4208 or 1-800-722-7300.

YOUR GROUP LONG-TERM DISABILITY PLAN

STATE OF DELAWARE

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Group Long Term Disability Benefits

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HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
Hartford, Connecticut
(Herein called Hartford Life)

CERTIFICATE OF INSURANCE
Under
The Group Insurance Policy
as of the Effective Date
Issued by
HARTFORD LIFE
to
The Policyholder

This is to certify that Hartford Life has issued and delivered the Group Insurance Policy to The Policyholder.

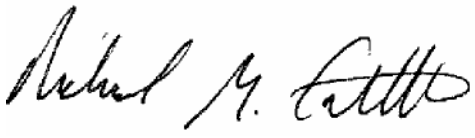
The Group Insurance Policy insures the employees of the Policyholder who:

- are eligible for the insurance;
- become insured; and
- continue to be insured;

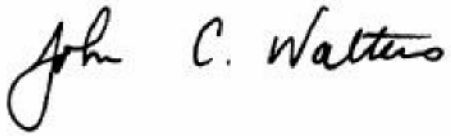
according to the terms of the Policy.

The terms of the Group Insurance Policy which affect an employee's insurance are contained in the following pages. This Certificate of Insurance and the following pages will become your Booklet-certificate. The Booklet-certificate is a part of the Group Insurance Policy.

This Booklet-certificate replaces any other which Hartford Life may have issued to the Policyholder to give to you under the Group Insurance Policy specified herein.



Richard G. Costello, *Secretary*



John C. Walters, *President*

SCHEDULE OF INSURANCE

Final interpretation of all provisions and coverages will be governed by the Group Insurance Policy on file with Hartford Life at its home office.

Policyholder:	STATE OF DELAWARE
Group Insurance Policy:	GLT-675467
Plan Effective Date:	January 1, 2006

THE BENEFITS DESCRIBED HEREIN ARE THOSE IN EFFECT AS OF JANUARY 1, 2009.

This plan of Disability Insurance provides you with loss of income protection if you become disabled from a covered accidental bodily injury, sickness or pregnancy.

Must you contribute toward the cost of coverage?
You do not contribute toward the cost of coverage.

Who is eligible for coverage?
Employees covered by the Delaware State Employees Pension Plan pursuant to 29 Del. C. Chapter 55 who are U.S. citizens or U.S. residents who are actively at work for one full day on or after January 1, 2006. Includes retired Delaware State Troopers who are employed in a pension covered position in the State Employees' Pension Plan as of July 1, 2008.

Maximum Monthly Benefit: $8,000

The **Minimum Monthly Benefit** will be the greater of:

- $100; or
- 10% of the benefit based on Monthly Income Loss before the deduction of Other Income Benefits.

Benefit Percentage: 60%

When will You become eligible? (Eligibility Waiting Period)
You are eligible on the later of either the Plan Effective Date or the date You enter an eligible class.

The Elimination Period is the period of time you must be Disabled before benefits become payable. It is the last to be satisfied of the following:

1. the first 182 consecutive calendar day(s) of any one period of Disability; or
2. with the exception of benefits required by state law, the expiration of any Employer sponsored short term disability benefits.

MAXIMUM DURATION OF BENEFITS TABLE

Age when disabled	Benefit duration (months)
Prior to age 60	To age 65
60	60
61	48
62	42
63	36
64	30
65	24
66	21
67	18
68	15
69+	12

Eligible Employees not vested as of December 31, 2005, in the Delaware State Employees Pension Plan will be enrolled automatically by the Employer. All new hires after the plan effective date will be enrolled automatically by the Employer. Eligible Employees vested as of December 31, 2005, in the Delaware State Employees Pension Plan must elect into the program before December 15, 2005. This is an irrevocable one-time election.

ELIGIBILITY AND ENROLLMENT

Who are Eligible Persons?
All persons in the class or classes shown in the Schedule of Insurance will be considered Eligible Persons.

When will You become eligible?
You will become eligible for coverage on either:
1. the Plan Effective Date, if You have completed the Eligibility Waiting Period; or if not
2. the date on which You complete the Eligibility Waiting Period.

See the Schedule of Insurance for the Eligibility Waiting Period.

How do you enroll?
Eligible Persons will be enrolled automatically by the Employer.

WHEN COVERAGE STARTS

When does Your coverage start?
If You are not required to contribute toward the plan's cost, Your coverage will start on the date You become eligible.

DEFERRED EFFECTIVE DATE

When will coverage become effective if a disabling condition causes You to be absent from work on the date it is to start?
If You are absent from work due to:
1. accidental bodily injury;
2. sickness;
3. pregnancy;
4. Mental Illness; or
5. Substance Abuse,

on the date Your insurance or increase in coverage would otherwise have become effective, Your effective date will be deferred. Your insurance, or increase in coverage will not become effective until You are Actively at Work for one full day.

CHANGES IN COVERAGE

Do coverage amounts change if there is a change in Your class or Your rate of pay?
Your coverage may increase or decrease on the date there is a change in Your class or Monthly Rate of Basic Earnings. However, no increase in coverage will be effective unless on that date You:
1. are an Active Full-time Employee; and
2. are not absent from work due to being Disabled.

If You were so absent from work, the effective date of such increase will be deferred until You are Actively at Work for one full day.

No change in Your Rate of Basic Earnings will become effective until the date we receive notice of the change.

What happens if the Employer changes the plan?
Any increase or decrease in coverage because of a change in the Schedule of Insurance will become effective on the date of the change, subject to the following limitations on an increase:
1. the Deferred Effective Date provision; and
2. Pre-existing Conditions Limitations.

BENEFITS

When do benefits become payable?
You will be paid a monthly benefit if:
1. You become Disabled while insured under this plan;
2. You are Disabled throughout the Elimination Period;
3. You remain Disabled beyond the Elimination Period;
4. You are, and have been during the Elimination Period, under the Regular Care of a Physician; and
5. You submit Proof of Loss satisfactory to us.

Benefits accrue as of the first day after the Elimination Period and are paid monthly.

When will benefit payments terminate?
We will terminate benefit payment on the first to occur of:
1. the date You are no longer Disabled as defined;
2. the date You fail to furnish Proof of Loss, when requested by us;
3. the date You are no longer under the Regular Care of a Physician, or refuse our request that You submit to an examination by a Physician;
4. the date You die;
5. the date Your Current Monthly Earnings exceed:
   a) 80% of Your Indexed Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation;
   b) an amount that is equal to the product of Your Indexed Pre-disability Earnings and the Benefit Percentage if You are receiving benefits for being Disabled from Any Occupation;
6. the date determined from the Maximum Duration of Benefits Table shown in the Schedule of Insurance, or your participation in the Pension Retirement Benefit with the State of Delaware regardless of age;
7. the date no further benefits are payable under any provision in this plan that limits benefit duration; or
8. the date You refuse to participate in a Rehabilitation program or, refuse to cooperate with or try:
   a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;
   b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Your Occupation;

c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation; or
d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the Essential Duties of Any Occupation, if You were receiving benefits for being disabled from Any Occupation,

provided a qualified Physician agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation; or

9. the date you receive retirement benefits from the Employer's Retirement Plan, unless:
   a) you were receiving them prior to becoming Disabled;
   b) you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.
10. the date you refuse to receive recommended treatment that is generally acknowledged by physicians to cure, correct or limit the disabling condition.

MENTAL ILLNESS AND SUBSTANCE ABUSE BENEFITS

Are benefits limited for Mental Illness or Substance Abuse?
If You are Disabled because of:
1. Mental Illness that results from any cause;
2. any condition that may result from Mental Illness;
3. alcoholism; or
4. the non-medical use of narcotics, sedatives, stimulants, hallucinogens, or any other such substance,

then, subject to all other Policy provisions, benefits will be payable:
1. only for so long as You are confined in a hospital or other place licensed to provide medical care for the disabling condition; or
2. when You are not so confined, a total of 24 months for all such Disabilities during Your lifetime.

RECURRENT DISABILITY

What happens if You Recover during the Elimination Period but become Disabled again?
Periods of Recovery during the Elimination Period will not interrupt the Elimination Period, provided the number of days You return to work as an Active Full-time Employee are less than one-half (1/2) the number of days of Your Elimination Period shown in the Schedule of Insurance.

Any day of a period of Recovery will not count towards the Elimination Period.

After the Elimination Period, when a return to work as an Active Full-time Employee is followed by a recurrent Disability, and such Disability is:
1. due to the same cause; or
2. due to a related cause; and
3. within 6 month(s) of the return to work,

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided the Group Insurance Policy remains in force.

If You return to work as an Active Full-time Employee for 6 month(s) or more, any recurrence of a Disability will be treated as a new Disability. A new Disability is subject to a new Elimination Period and a new Maximum Duration of Benefits. The Elimination Period and Maximum Duration of Benefits Table are in the Schedule of Insurance.

The term "Period of Disability" as used in this provision means a continuous length of time during which You are Disabled under this plan.

CALCULATION OF MONTHLY BENEFIT

How are Disability benefits calculated?

Return to Work Incentive
If You remain Disabled after the Elimination Period, but work while You are Disabled, we will determine Your Monthly Benefit for a period of up to 12 consecutive months as follows:
1. multiply Your Pre-Disability Earnings by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

Current Monthly Earnings will not be used to reduce Your Monthly Benefit. However, if the sum of Your Monthly Benefit and Your Current Monthly Earnings exceeds 100% of Your Pre-disability Earnings, we will reduce Your Monthly Benefit by the amount of excess.

The 12 consecutive month period will start on the last to occur of:
1. the day You first start such work; or
2. the end of the Elimination Period.

If You are Disabled and not receiving benefits under the Return to Work Incentive, we will calculate Your Monthly Benefit as follows:
1. multiply Your Monthly Income Loss by the Benefit Percentage;
2. compare the result with the Maximum Benefit; and
3. from the lesser amount, deduct Other Income Benefits.

The result is Your Monthly Benefit.

What happens if the sum of the Monthly Benefit, Current Monthly Earnings and Other Income Benefits exceeds 100% of Pre-disability Earnings?
We will reduce Your Monthly Benefit by the amount of the excess. However, Your Monthly Benefit will not be less than the Minimum Monthly Benefit shown in the Schedule of Insurance.

If an overpayment occurs, we may recover all or any portion of an overpayment by reducing or withholding future benefit payments, including the Minimum Monthly Benefit.

How is the benefit calculated for a period of less than a month?
If a Monthly Benefit is payable for less than a month, we will pay 1/30 of the Monthly Benefit for each day You were Disabled.

Benefit Percentages and Maximum Benefits are shown in the Schedule of Insurance.

REHABILITATION

What is Rehabilitation?
Rehabilitation is a process of working together to plan, adapt, and put into use options and services to meet Your return to work needs.

A Rehabilitation program may include, when we consider it to be appropriate, any necessary and feasible:
1. vocational testing;
2. vocational training;
3. alternative treatment plans such as:
   a) support groups;
   b) physical therapy;
   c) occupational therapy; and
   d) speech therapy;
4. work-place modification to the extent not otherwise provided;
5. job placement; and
6. transitional work, and
7. similar services.

FAMILY CARE CREDIT BENEFIT

What if You must incur expenses for Family Care Services in order to participate in a Rehabilitative program? If You are working as part of a program of Rehabilitative Employment, we will, for the purpose of calculating Your benefit, deduct the cost of Family Care from earnings received from a Rehabilitative program, subject to the following limitations:
1. Family Care means the care or supervision of:
   a) Your children under age 13; or
   b) a member of Your household who is mentally or physically handicapped and dependent upon You for support and maintenance;
2. the maximum monthly deduction allowed for each qualifying child or family member is:
   a) $350 during the first 12 months of Rehabilitative Employment; and
   b) $175 thereafter,

   but in no event may the deduction exceed the amount of Your monthly earnings;
3. Family Care Credits may not exceed a total of $2,500 during a calendar year;
4. the deduction will be reduced proportionally for periods of less than a month;
5. the charges for Family Care must be documented by a receipt from the caregiver;
6. the credit will cease on the first to occur of the following:
   a) You are no longer in a Rehabilitative program; or
   b) Family Care Credits for 24 months have been deducted during Your Disability; and
7. no Family Care provided by an immediate relative of the family member receiving the care will be eligible as a deduction under this provision. An immediate relative is a spouse, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter or grandchild.

Your Current Monthly Earnings after the deduction of Your Family Care Credit will be used to determine Your Monthly Income Loss. In no event will You be eligible to receive a Monthly Benefit under the plan if Your Current Monthly Earnings before the deduction of the Family Care Credit exceed 80% of Your Indexed Pre-disability Earnings.

SURVIVOR INCOME BENEFIT

Will Your survivors receive a benefit if You should die while receiving Disability Benefits?
If You die while receiving benefits under this plan, a Survivor Benefit will be payable to:
1. Your surviving Spouse; or
2. Your surviving Child(ren), in equal shares, if there is no surviving Spouse.

If a minor Child is entitled to benefits, we may, at our option, make benefit payments to the person caring for and supporting the Child until a legal guardian is appointed.

The Benefit is one payment of an amount that is 3 times the lesser of:
1. Your Monthly Income Loss multiplied by the Benefit Percentage; or
2. the Maximum Monthly Benefit shown in the Schedule of Insurance.

If there is no surviving Spouse or Child(ren), payment will be made to Your estate, unless there is none. In this case, no payment will be made.

However, we will first apply the Survivor Benefit to any overpayment which may exist on Your claim.

The following terms apply to this Benefit:
"Spouse" means Your wife or husband who:
1. is mentally competent; and
2. was not legally separated from You at the time of Your death.

"Child" means Your son or daughter under age 21 who is dependent on You for financial support.

WORKPLACE MODIFICATION BENEFIT

Will our Rehabilitation program provide for modifications to the workplace to accommodate a Disabled employee's return to work?
We will reimburse Your Employer for the expense of reasonable modifications to Your workplace to accommodate Your Disability and enable You to return to work as an Active Full-time Employee. To qualify for this benefit:
1. Your Disability must be covered by this plan;
2. the Employer must agree to make modifications to the workplace in order to reasonably accommodate Your return to work and the performance of the essential duties of Your job; and
3. any proposed modifications must be approved in writing by us.

Benefits paid for such workplace modification shall not exceed the amount equal to Your Pre-disability Earnings multiplied by the Benefit Percentage.

We have the right, at our expense, to have You examined or evaluated by:
1. a physician or other health care professional; or
2. a vocational expert or rehabilitation specialist,

of our choice so that we may evaluate the appropriateness of any proposed modification.

The Employer's costs for approved modifications will be reimbursed after:
1. the proposed modifications made on Your behalf are complete;
2. we have been provided written proof of the expenses incurred to provide such modification; and
3. You have returned to work as an Active Full-time Employee.

This Workplace Modification benefit will not be payable if:
1. the Employer does not incur any cost in making the modification;
2. we have not given written approval of the modification prior to expenses being incurred; or
3. You become self-employed, or return to work for another employer.

Workplace Modification means change in Your work environment, or in the way a job is performed, to allow You to perform, while Disabled, the Essential Duties of Your job. Payment of this benefit will not reduce or deny any benefit You are eligible to receive under the terms of this plan.

PRE-EXISTING CONDITIONS LIMITATIONS

Are there any other limitations on coverage?

For employees with a date of hire on or after January 1, 2006 no benefit will be payable under the plan for any Disability that is due to, contributed to by, or results from a Pre-existing Condition, unless such Disability begins:

1. after the last day of 12 consecutive month(s) while insured during which you receive no medical care for the Pre-existing Condition; or
2. after the last day of 12 consecutive month(s) during which you have been continuously insured under this plan.

The amount of a benefit increase, which results from a change in benefit options, a change of class or a change in the plan, will not be paid for any Disability that is due to, contributed to by, or results from a Pre-existing condition, unless such Disability begins:

1. after the last day of 12 consecutive month(s) while insured for the increased benefit amount during which you receive no medical care for the Pre-existing Condition; or
2. after the last day of 12 consecutive month(s) during which you have been continuously insured for the increased benefit amount.

Pre-existing Condition means:

1. any accidental bodily injury, sickness, Mental Illness, pregnancy, or episode of Substance Abuse; or
2. any manifestations, symptoms, findings, or aggravations related to or resulting from such accidental bodily injury, sickness, Mental Illness, pregnancy, or Substance Abuse;

for which you received Medical Care during the 3 month period that ends the day before:

1. your effective date of coverage; or
2. the effective date of a Change in Coverage.

Medical Care is received when:

1. a Physician is consulted or medical advice is given; or
2. treatment is recommended, prescribed by, or received from a Physician.

Treatment includes but is not limited to:

1. medical examinations, tests, attendance or observation; and
2. use of drugs, medicines, medical services, supplies or equipment.

EXCLUSIONS

What Disabilities are not covered?

The plan does not cover, and no benefit shall be paid for any Disability:

1. unless You are under the Regular Care of a Physician;
2. that is caused or contributed to by war or act of war (declared or not);
3. caused by Your commission of or attempt to commit a felony, or to which a contributing cause was Your being engaged in an illegal occupation; or
4. caused or contributed to by an intentionally self-inflicted injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:

1. was sponsored by the Employer; and
2. was terminated before the Effective Date of this plan,

no benefits will be payable for the Disability under this plan.

TERMINATION

When does your coverage terminate?

You will cease to be covered on the earliest to occur of the following dates:

1. the date the Group Insurance Policy terminates;
2. the date the Group Insurance Policy no longer insures your class;
3. the date premium payment is due but not paid by the Employer;
4. the last day of the period for which you make any required premium contribution, if you fail to make any further required contribution;
5. the date you cease to be an Active Full-time or Part-time employee in an eligible class; or
6. the date your Employer ceases to be a Participant Employer, if applicable.

May coverage be continued during a leave of absence?

If You are granted a leave of absence, the Employer may continue Your insurance for 24 month(s) following the month coverage would have terminated subject to the following:

1. the leave authorization is in writing or is documented as a leave for military purposes;
2. the required premium must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the termination of the Group Insurance Policy;
   c) non-payment of premium when due by the Policyholder or You;
   d) the Group Insurance Policy no longer insures Your class; or
   e) Your Employer ceases to be a Participant Employer, if applicable.

Does Your coverage continue if Your employment terminates because You are Disabled?

If You are Disabled and You cease to be an Active Full-time Employee, Your insurance will be continued:

1. during the Elimination Period while You remain Disabled by the same Disability; and
2. after the Elimination Period for as long as You are entitled to benefits under the Policy.

Must premiums be paid during a Disability?

No premium will be due for You:

1. after the Elimination Period; and
2. for as long as benefits are payable.

Do benefits continue if the plan terminates?

If You are entitled to benefits while Disabled and the Group Insurance Policy terminates, benefits:

1. will continue as long as You remain Disabled by the same Disability; but
2. will not be provided beyond the date we would have ceased to pay benefits had the insurance remained in force.

Termination for any reason of the Group Insurance Policy will have no effect on our liability under this provision.

May coverage be continued during a family or medical leave?

If You are granted a leave of absence according to the Family and Medical Leave Act of 1993, Your Employer may continue Your insurance for up to 12 weeks, or 26 weeks if You qualify for Family Military Leave, or longer if required by state law, following the date Your coverage would have terminated, subject to the following:

1. the leave authorization must be in writing;
2. the required premium for You must be paid;
3. Your benefit level, or the amount of earnings upon which Your benefit may be based, will be that in effect on the day before said leave commenced; and
4. such continuation will cease immediately if one of the following events should occur:
   a) the leave terminates prior to the agreed upon date;
   b) the termination of the Group Insurance Policy;
   c) non-payment of premium when due by the Policyholder or You;
   d) the Group Insurance Policy no longer insures Your class; or
   e) Your Employer ceases to be a Participant Employer, if applicable.

GENERAL PROVISIONS

What happens if facts are misstated?
If material facts about You were not stated accurately:
1. Your premium may be adjusted; and
2. the true facts will be used to determine if, and for what amount, coverage should have been in force.

No statement made by You relating to Your insurability will be used to contest the insurance for which the statement was made after the insurance has been in force for two years during Your lifetime. In order to be used, the statement must be in writing and signed by You.

When should we be notified of a claim?
You must give us written notice of a claim within 30 days after Disability starts. If notice cannot be given within that time, it must be given as soon as possible. Such notice must include Your name, Your address and the Group Insurance Policy number.

Are special forms required to file a claim?
When we receive a notice of claim, You will be sent forms for providing us with Proof of Loss. We will send these forms within 15 days after receiving a notice of claim. If we do not send the forms within 15 days, You may submit any other written proof which fully describes the nature and extent of Your claim.

What is Proof of Loss?
Proof of Loss may include but is not limited to the following:
1. documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Earnings or income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2. any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;
3. the names and addresses of all:
   a) Physicians and practitioners of healing arts You have seen or consulted;
   b) hospitals or other medical facilities in which You have been seen or treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4. Your signed authorization for us to obtain and release:
   a) medical, employment and financial information; and
   b) any other information we may reasonably require;
5. Your signed statement identifying all Other Income Benefits; and
6. proof that You and Your dependents have applied for all Other Income Benefits which are available. You will not be required to claim any retirement benefits which You may only get on a reduced basis.

All proof submitted must be satisfactory to us.

When must Proof of Loss be given?
Written Proof of Loss must be sent to us within 90 days after the start of the period for which we owe payment. If proof is not given by the time it is due, it will not affect the claim if:
1. it was not possible to give proof within the required time; and
2. proof is given as soon as possible; but
3. not later than 1 year after it is due, unless You are not legally competent.

We may request Proof of Loss throughout Your Disability. In such cases, we must receive the proof within 30 days of the request.

What additional Proof of Loss is Hartford Life entitled to?
To assist us in determining if You are Disabled, or to determine if You meet any other term or condition of the policy, we have the right to require You to:
1. meet and interview with our representative; and
2. be examined by a doctor, vocational expert, functional expert, or other medical or vocational professional of our choice.

Any such interview, meeting or examination will be:
1. at our expense; and
2. as reasonably required by us.

We reserve the right to determine if Your Proof of Loss is satisfactory. Unless we determine You have a valid reason for refusal, we may deny, suspend or terminate Your benefits if You refuse to be examined, or meet to be interviewed.

When must one apply for Social Security Benefits?
Upon Hartford Life's request, You must apply for Social Security disability benefits. You must apply within 45 days from the date of Hartford Life's request. If the Social Security Administration denies Your claim for benefits, You will be required to follow the process established by the Social Security Administration to:
1. request a reconsideration of the denial; and
2. if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals on Your claim for Social Security benefits.

How does Hartford Life estimate disability benefits under the United States Social Security Act?
We reserve the right to reduce Your Monthly Benefit by estimating the Social Security disability benefits You or Your Dependent may be eligible to receive.

When we determine that You or Your Dependent may be eligible for benefits, we may estimate the amount of these benefits. We may reduce Your Monthly Benefit by the estimated amount.

Your Monthly Benefit will not be reduced by estimated Social Security disability benefits if:
1. You apply for Social Security disability benefits and pursue all required appeals in accordance with the provision entitled "When must one apply for Social Security Benefits?"; and
2. You have signed a form authorizing the Social Security Administration to release information about awards directly to us; and
3. You have signed and returned Hartford Life's reimbursement agreement, which confirms that You agree to repay all overpayments.

If we have reduced Your Monthly Benefit by an estimated amount and:
1. You or Your Dependent are later awarded Social Security disability benefits, we will adjust Your Monthly Benefit when we receive proof of the amount awarded; or
2. Your application for Social Security disability benefits has been denied, we will adjust Your Monthly Benefit when You provide us proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If we have not reduced Your Monthly Benefit by an estimated Social Security disability benefit, we will adjust Your Monthly Benefit upon receipt of proof of the amount of Social Security disability benefits awarded.

If we owe You a refund, we will make such refund in a lump sum. If Your Monthly Benefit has been overpaid, You must make a lump sum refund to us equal to all overpayments, in accordance with the provision entitled "How does Hartford Life exercise the right to recover overpayments?"

When does an overpayment occur?
An overpayment occurs:
1. when we determine that the total amount we have paid in benefits is more than the amount that was due to You under the plan; or
2. when payment is made by us that should have been made under another group plan.

This includes, but is not limited to, overpayments resulting from:

1. retroactive awards received from sources listed in the Other Income Benefits definition;
2. failure to report, or late notification to us of any Other Income Benefit(s) or earned income;
3. misstatement;
4. fraud; or
5. any error we may make.

In case of an overpayment, we have the right to recover the payment from one or more of the following:

1. You;
2. any other organization;
3. any other insurance company; and
4. any other person to or for whom payment was made.

How does Hartford Life exercise the right to recover overpayments?
We have the right to recover from You any amount that we determine to be an overpayment. You have the obligation to refund to us any such amount. Our rights and Your obligations in this regard may also be set forth in the reimbursement agreement You will be required to sign when You become eligible for benefits under this Plan.

If benefits are overpaid on any claim, You must reimburse Hartford Life within 30 days.

If reimbursement is not made in a timely manner, Hartford Life has the right to:

1. recover such overpayments from Your estate;
2. reduce or offset against any future benefits payable to You or Your survivors , including the Minimum Monthly Benefit, until full reimbursement is made. Payments may continue when the overpayment has been recovered;
3. refer Your unpaid balance to a collection agency; and
4. pursue and enforce all its legal and equitable rights in court.

Who gets the benefit payments?
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to Your estate, a person who is a minor or a person who is not legally competent, then we may pay up to $1,000 to any of Your relatives who is entitled to it in our opinion. Any such payment shall fulfill our responsibility for the amount paid.

When are payment checks issued?
When we determine that You are Disabled and eligible to receive benefits, we will pay accrued benefits at the end of each month that You are Disabled. We may, at our option, make an advance benefit payment based on our estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as satisfactory Proof of Loss is received.

What notification will You receive if Your claim is denied?
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written decision will:

1. give the specific reason(s) for the denial;
2. make specific reference to the Policy provisions on which the denial is based;
3. provide a description of any additional information necessary to prepare a claim and an explanation of why it is necessary; and
4. provide an explanation of the review procedure.

What recourse do You have if Your claim is denied?
On any claim, You or Your representative may appeal to us for a full and fair review. You may:

1. request a review upon written application within 180 days of the claim denial;
2. request copies of all documents, records, and other information relevant to Your claim; and
3. submit written comments, documents, records and other information relating to Your claim.

We will make a decision no more than 45 days after we receive Your appeal unless we determine special circumstances exist that require an extension of time to process the appeal. If Your appeal requires extension, we will make our decision no more than 90 days after we receive Your appeal. The written decision will include specific references to the Policy provisions on which the decision is based.

When can legal action be started?
Legal action cannot be taken against us:
1. sooner than 60 days after due Proof of Loss has been furnished; or
2. three years after the time written Proof of Loss is required to be furnished according to the terms of the Policy (five years in Kansas; six years in South Carolina).

What are our subrogation rights?
If an Insured Person:
1. suffers a Disability because of the act or omission of a third party;
2. becomes entitled to and is paid benefits under the Group Insurance Policy in compensation for lost wages; and 3. does not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time,

then we will be subrogated to any rights the Insured Person may have against the third party and may, at our option, bring legal action to recover any payments made by us in connection with the Disability.

How do we deal with fraud?
Insurance Fraud occurs when You and/or Your Employer, with the intent to injure, defraud or deceive us, provides us with false information or files a claim for benefits that contains any false, incomplete or misleading information. It is a crime if You and/or Your Employer commit Insurance Fraud. We will use all means available to us to detect, investigate, deter and prosecute those who commit Insurance Fraud. We will pursue all available legal remedies if You and/or Your Employer perpetrates Insurance Fraud.

Who interprets policy terms and conditions?
We have full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy.

DEFINITIONS

The terms listed will have these meanings.

Actively at Work
You will be considered to be actively at work with your Employer on a day which is one of your Employer's scheduled work days if you are performing, in the usual way, all of the regular duties of your job on a Full-time basis on that day. You will be deemed to be actively at work on a day which is not one of your Employer's scheduled work days only if you were actively at work on the preceding scheduled work day.

Active Full-time Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. The employee must work the number of hours in the Employer's normal work week. This must be at least the number of hours indicated in the Schedule of Insurance.

Any Occupation means an occupation for which you are qualified by education, training or experience, and that has an earnings potential greater than an amount equal to the lesser of the product of your Indexed Pre-disability Earnings and the Benefit Percentage and the Maximum Monthly Benefit shown in the Schedule of Insurance.

Current Monthly Earnings means the monthly earnings you receive from:
1. the Employer while Disabled;
2. other employment.

However, if the other employment is a job you held in addition to Active Full-time Employment with the Employer, then:

1. during the Elimination Period, and while eligible to receive benefits for being Disabled from Your Occupation;
2. any earnings from this other employment will be Current Monthly Earnings only to the extent that such earnings exceed the average monthly earnings you were receiving from this other job during the 6 month period immediately prior to becoming Disabled.

Current Monthly Earnings will also include the amount of pay for another or modified job position, which may be offered to you by the Employer or other employer, if you refuse the offer. The requirements of such position must be within your capabilities as described by your Physician, and consistent with your education, training and experience.

Disability or Disabled means:

1. during the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation;
2. for the 24 months following the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation, and as a result your Current Monthly Earnings are less than 80% of your Indexed Pre-disability Earnings;
3. after that, you are prevented from performing one or more of the Essential Duties of Any Occupation.

If at the end of the Elimination Period, you are prevented from performing one or more of the Essential Duties of Your Occupation, but your Current Monthly Earnings are greater than 80% of your Pre-disability Earnings, your Elimination Period will be extended for a total period of 12 months from the original Date of Disability, or until such time as your Current Monthly Earnings are less than 80% of your Pre-disability Earnings, whichever occurs first.

Your Disability must be the result of:

1. accidental bodily injury;
2. sickness;
3. Mental Illness;
4. Substance Abuse; or
5. pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that you are Disabled.

Employer means the Policyholder.

Essential Duty means a duty that:

1. is substantial, not incidental;
2. is fundamental or inherent to the occupation;
3. can not be reasonably omitted or changed.

To be at work for the number of hours in your regularly scheduled workweek is also an Essential Duty.

Indexed Pre-disability Earnings when used in this policy means your Pre-disability Earnings adjusted annually by adding the lesser of:

1. 10%; or
2. the percentage change in the Consumer Price Index (CPI-W).

The adjustment is made January 1st each year after You have been Disabled for 12 consecutive months, and if You are receiving benefits at the time the adjustment is made.

The term Consumer Price Index (CPI-W) means the index for Urban Wage Earners and Clerical Workers published by the United States Department of Labor. It measures on a periodic (usually monthly) basis the change in the cost of typical urban wage earners' and clerical workers' purchase of certain goods and services. If the index is discontinued or changed, we may use another nationally published index that is comparable to the CPI-W.

For the purposes of this benefit, the percentage change in the CPI-W means the difference between the current year's CPI-W as of July 31st, and the prior year's CPI-W as of July 31st, divided by the prior year's CPI-W.

Mental Illness means any psychological, behavioral or emotional disorder or ailment of the mind, including physical manifestations of psychological, behavioral or emotional disorders, but excluding demonstrable, structural brain damage.

Monthly Benefit means a monthly sum payable to you while you are Disabled, subject to the terms of the Group Insurance Policy.

Monthly Income Loss is the difference of your Pre-disability Earnings less your Current Monthly Earnings.

Monthly Rate of Basic Earnings means your regular monthly rate of pay from the Employer just prior to the date you become Disabled:

1. including contributions you make through a salary reduction agreement with the Employer to:
   a) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
   b) an executive non qualified deferred compensation arrangement; or
   c) a salary reduction arrangement under an IRC Section 125 plan; and
2. not including commissions, shift differential pay, overtime pay or expense reimbursements for the same period as above.

Other Income Benefits mean the amount of any benefit for loss of income, provided to you or to your family, as a result of the period of Disability for which you are claiming benefits under this plan. This includes any such benefits for which you or your family are eligible or that are paid to you, to your family or to a third party on your behalf, pursuant to any:

1. temporary disability benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2. governmental law or program that provides disability or unemployment benefits as a result of your job with the Employer;
3. plan or arrangement of coverage, whether insured or not, or as a result of employment by or association with the Employer or as a result of membership in or association with any group, association, union or other organization;
4. mandatory "no-fault" automobile insurance plan;
5. disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act,

   that you, your spouse and children are eligible to receive because of your Disability; or
6. disability benefit from the Veteran's Administration, or any other foreign or domestic governmental agency:
   a) that begins after you become Disabled; or
   b) if you were receiving the benefit before becoming Disabled, the amount of any increase in the benefit that is attributed to your Disability.

Other Income Benefits also mean any payments that are made to you, your family, or to a third party on your behalf, pursuant to any:

1. disability benefit under the Employer's Retirement Plan;
2. permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges of such benefits;
3. portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings;
4. retirement benefit from a Retirement Plan that is wholly or partially funded by employer contributions, unless:
   a) you were receiving it prior to becoming Disabled; or
   b) you immediately transfer the payment to another plan qualified by the United States Internal Revenue Service for the funding of a future retirement.

Other Income Benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions; or

5. retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act; the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act,

   that you, your spouse and children receive because of your retirement, unless you were receiving them prior to becoming Disabled.

If you are paid Other Income Benefits in a lump sum or settlement, you must provide proof satisfactory to us of:
1. the amount attributed to loss of income; and
2. the period of time covered by the lump sum or settlement.

We will pro-rate the lump sum or settlement over this period of time. If you cannot or do not provide this information, we will assume the entire sum to be for loss of income, and the time period to be 24 months. We may make a retroactive allocation of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of your claim. Please see the provision entitled, "What happens if benefits are overpaid?"

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:
1. takes effect after the date benefits become payable under this plan; and
2. is a general increase which applies to all persons who are entitled to such benefits.

Physician means a person who is:
1. a doctor of medicine, osteopathy, psychology or other healing art recognized by us;
2. licensed to practice in the state or jurisdiction where care is being given;

and 3. practicing within the scope of that license.

Pre-disability Earnings means your Monthly Rate of Basic Earnings in effect on the day before you became Disabled.

Prior Plan means the long term disability insurance carried by the Employer on the day before the Plan Effective Date.

Recover or **Recovery** means that you are no longer Disabled and have returned to work with the Employer and premiums are being paid for you.

Regular Care of a Physician means you are attended by a Physician, who is not related to you:
1. with medical training and clinical experience suitable to treat your disabling condition; and
2. whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research and rehabilitative organizations; and c) administered as often as needed,

to achieve the maximum medical improvement.

Retirement Plan means a defined benefit or defined contribution plan that provides benefits for your retirement and which is not funded wholly by your contributions. It does not include:
1. a profit sharing plan;
2. thrift, savings or stock ownership plans;
3. a non-qualified deferred compensation plan; or
4. an individual retirement account (IRA), a tax sheltered annuity (TSA), Keogh Plan, 401(k) plan or 403(b) plan.

State Pension Plan participant means You, if You are “a Full-time or Regular Part-time Employee of:
- the State;
- the State Department of Education (formerly Department of Public Instruction);

- a School District;
- the University of Delaware (excluding most faculty and designated professional staff);
- Delaware State University;
- Delaware Technical & Community College;
- Solid Waste Authority;
- Office of Disciplinary Council;
- Prothonotary's Office; or
- A State Agency supported in whole or part by federal funds granted to the State;

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the substance; or
4. the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

We, us or **our** means the Hartford Life and Accident Insurance Company.

You, your, Insured Person means the Insured Person to whom this Booklet-certificate is issued.

Your Occupation, if used in this Booklet-certificate, means your occupation as it is recognized in the general workplace. Your Occupation does not mean the specific job you are performing for a specific employer or at a specific location.

The Plan Described in this Booklet

is Insured by the

Hartford Life and Accident Insurance Company

Hartford, Connecticut

Member of The Hartford Insurance Group

STATE OF DELAWARE
EXECUTIVE DEPARTMENT
OFFICE OF MANAGEMENT AND BUDGET

TO: Employee ID:

FROM: Laura Pomatto

RE: Transition from Short Term Disability (STD) to long Term Disability (LTD)

DATE:

We have been notified that you have applied for LTD benefits from the State of Delaware's Disability Insurance Program. Any insurance coverage(s) you currently have with your active agency will end with the termination of your STD. In order to have your coverage continue you must complete the enclosed applications to participate in the Pension Group health, vision, dental and blood bank plans. Information is enclosed explaining the options available to you for each plan. Please complete the appropriate forms (application or refusal) indicating your coverage choices and return them to the Office of Pensions as soon as possible to ensure that you do not have a gap in coverage. To obtain more information regarding your benefit options, please review the Statewide Benefits website at www.ben.omb.delaware.gov.

You will be responsible for paying the monthly premiums for the coverage you select. The Hartford will be notified of the cost of your premiums and they will deduct those premiums from your monthly LTD payments if they are able. If your premiums are not able to be deducted from your LTD benefit, you will be responsible for paying them by personal check to the Office of Pensions each month.

If you are approved for Social Security disability benefits, you will be become eligible for Medicare Parts A and B after twenty-four (24) months. You, a spouse, or any eligible dependents must accept both Medicare Parts A and B when eligible. Upon receipt of your Medicare card, please contact the Office of Pensions at 302-739-4208 or 800-722-7300.

Please contact Minnesota Life directly at 888-658-0193 for questions regarding your Minnesota Life coverage. If you are also enrolled in a life insurance program sponsored by your school district, please contact your district representative for instructions to apply for the waiver of premium benefit, if applicable.

When your STD benefit ends, regardless of whether or not you are approved for LTD, you are responsible for making sure that your most recent employing agency has submitted a vested pension application to the Office of Pensions on your behalf. This will ensure that once you are eligible, your Pension benefits will start in a timely manner. Approximately three months prior to the effective date of your State of Delaware service pension, you will receive a letter requesting several personal and payroll documents. Upon receipt of these documents, your service pension will be calculated based on your entire State service, including the period during which you were receiving disability payments from the State of Delaware's Disability Insurance Program.

If you have any questions, please contact the Office of Pensions at 302-739-4208 or 800-722-7300.

OFFICE OF PENSIONS
860 SILVER LAKE BLVD., SUITE 1 • MCARDLE BUILDING • DOVER, DE 19904
PHONE: (302) 739-4208 • TOLL FREE: (800) 722-7300 • FAX: (302) 739-6129 • WWW.OMB.DELAWARE.GOV

Minnesota Life Insurance Company

Group Universal Life (GUL) Insurance for Disabled Employees

The State of Delaware's Group Universal Life (GUL) insurance program includes an important feature to protect disabled employees. If you become totally disabled while enrolled in the GUL program, the State will continue to pay your (employee only) life insurance premium for as long as you are deemed totally disabled or until you attain age 65, whichever occurs first. If you cease to be totally disabled prior to age 65, or if you fail to give proof of your continued disability when requested by Minnesota Life, the State's payment of your insurance premium will cease, but you may continue your coverage if you promptly resume paying the applicable premium for the coverage.

During your approved disability, the State will pay the minimum premium required to keep your life insurance in effect. Your Accidental Death and Dismemberment (AD&D) coverage terminates upon the commencement of the premium waiver benefit. If you want to add to the cash value of your policy, you may continue to pay any additional premium payments yourself directly to Minnesota Life. Also, if you want to continue any spouse or child life insurance you have, you must contact Minnesota Life within 31 days to convert those coverage(s) to an individual policy.

Eligibility

In order to be eligible for this benefit, you must be enrolled in the GUL program for at least one year prior to becoming totally disabled. If you become totally disabled after this one-year period and are approved for the premium waiver benefit by Minnesota Life, the State of Delaware will begin to pay your premiums after the exhaustion of the elimination period or when you are approved for the benefit, whichever is later. Once you have been approved, you will be asked from time to time to provide proof that you continue to be totally disabled. If you fail to provide such proof to Minnesota Life, your insurance premiums will no longer be paid for you by the State of Delaware.

Definition of Total Disability

Employees with a Date of Disability on or before December 31, 2012

For purposes of this special "premium waiver" feature, "total disability" or "totally disabled" means that during the 9 month elimination period and subsequent 21 months, you are prevented from performing one or more of the essential duties of your occupation and as a result, your current monthly earnings are less than 80% of your pre-disability earnings; after those 30 months, you are prevented from performing one or more of the essential duties of any occupation for which you are fit through education, experience or training.

Employees with a Date of Disability on or after January 1, 2013

"Total disability' or totally disabled means that during the 6 month elimination period and subsequent 24 months, you are prevented from performing one or more of the essential duties of your occupation and as a result, your current monthly earnings are less than 80% of your pre-disability earnings; after those 30 months, you are prevented from performing one or more of the essential duties of any occupation for which you are fit through education, experience, or training.

Applying for Premium Waiver

Employees awarded Long Term Disability (LTD) benefits by The Hartford who are enrolled in the Group Universal Life (GUL) Program will automatically be awarded waiver of premium status by Minnesota Life for as long as you are deemed to be totally disabled or until reaching age 65, whichever occurs first. You must continue to pay the premiums for dependent life coverage if applicable.

Summary

Please contact Minnesota Life directly by telephone at 877-215-1489 or by email at lifebenefits@securian.com for questions regarding your Minnesota Life coverage. You may also contact the Statewide Benefits Office by telephone at 302-739-8331 with questions regarding the GUL program.

During the period that you remain totally disabled, you must alert Minnesota Life of any change to your address and/or telephone numbers. If you are also enrolled in a life insurance program sponsored by your school district, please contact your district representative for instructions on applying for the waiver of premium benefit, if applicable.

While the State hopes and intends to continue this “premium waiver” feature indefinitely, the State reserves the right at any time, in its sole discretion, to modify or eliminate this feature without advance notice to employees or disabled employees.

IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

STATE OF DELAWARE OFFICE OF PENSIONS
APPLICATION FOR HEALTH CARE COVERAGE

Revised March 2014

LTD

A. REASON FOR APPLICATION

☐New coverage
☐Change coverage
☐Information change
☐Medicare Eligible
☐Refuse coverage *(see Section F)*

ADD DEPENDENTS DUE TO:
Date of event checked: ____________
☐ Marriage/Civil Union
☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship

CANCEL DEPENDENTS DUE TO:
Date of event checked: ____________
☐Divorce ☐ Death
☐Over age ☐ Other
☐No longer dependent

REINSTATE COVERAGE DUE TO:
Date of event checked: _____________
☐Administrative error
☐Other

B. PERSONAL INFORMATION

☐ Male ☐ Female ☐ Retiree ☐ Surviving spouse ☐ Non-employee	Date of Retirement (month, day, year)	Social Security Number	Agency or School District **PENSION OFFICE**		
Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)
Street Address		City	State	Zip Code	

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Individual ☐ Individual & Spouse ☐ Individual & child (ren) ☐Family

**Relationship of Spouse applies to Spouse or Civil Union Spouse*
**Relationship of Dependent applies to Dependent(s) and/or Civil Union Dependent(s)*

PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE:

☐Highmark First State Basic ☐Highmark IPA/HMO ☐Aetna HMO ☐Highmark Comp PPO
☐ Highmark Consumer Directed Health Gold ☐Aetna Consumer Directed Health Gold

OR

MEDICARE SUPPLEMENT COVERAGE CHOICE:

☐Highmark Special Medicfill with prescription ☐Highmark Special Medicfill without prescription

MEDICARE INFORMATION: Must enroll if eligible
Please include copy of Medicare card with this application.

Applicant's Medicare #: ____________________________

Part A Effective Date: ____________________________

Part B Effective Date: ____________________________

D. ELIGIBLE DEPENDENTS TO BE COVERED / PRIMARY CARE PHYSICIAN SELECTION

***If you choose Highmark DE IPA/HMO or Aetna HMO coverage, you MUST select a primary care physician (PCP) for yourself, spouse and all eligible dependents**
If more space Is needed to list dependents, please use a separate sheet of paper and attach It to this application.

Name of Your Pri mary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

☐Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Cancel	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Blue Cross Blue Shield contract? ☐Y ☐N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Delaware or Aetna. 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark Delaware or Aetna, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis treatment or other health care services they render to me or my covered dependents its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark Delaware or Aetna to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law.

I **ELECT** to participate in the State Health Insurance and do agree to the above terms.

Signature:____Date:______________

I elect **NOT** to participate in the State Health Insurance.

Signature: ______________________________________Date:___________________

REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service**. I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

_____
Signature

_____
Date

LTD

OFFICE OF PENSIONS

HEALTH INSURANCE COVERAGE

REFUSAL

I elect not to participate in a health insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.
Form DR (4/2007) §

LTD

STATE OF DELAWARE OFFICE OF PENSIONS
DENTAL APPLICATION

Effective Date

_____
(MM/DD/YY)

IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

Please check the applicable box or boxes.

☐ New Enrollment ☐ Name Change ☐ Change of Dependents
☐ Coverage Change ☐ Address Change ☐ Termination

Please select who coverage is for:
☐ Employee
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Family

Please select one dental plan of your choice:
☐ Delta Dental #1260-0001
☐ Dominion Dental #15339-*Must provide Dentist

NOTE: INCOMPLETE INFORMATION ON THIS FORM WILL DELAY YOUR ENROLLMENT. PLEASE PRINT CLEARLY.

Social Security Number	Employee Name(Last ,First, Middle Initial		Date of Birth
Home Address			**Home Phone**
City	**State**	**Zip Code**	**Work Phone**
Date of Marriage	**Marital Status** ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated		
Agency **PENSION OFFICE**			

PLEASE LIST HERE ALL FAMILY MEMBERS TO BE COVERED BY THIS ENROLLMENT

Last Name	First Name	MI	Sex	Date of Birth	Social Security	*Primary Care Dentist Name	*Primary Care Dentist Code
Employee				/ /	- -		
Spouse				/ /	- -		
Child ☐fulltime student ☐handicapped				/ /	- -		
Child ☐fulltime student ☐handicapped				/ /	- -		
Child ☐fulltime student ☐handicapped				/ /	- -		

IMPORTANT: Do you or your dependent(s) have other Group Dental Coverage? ☐ YES ☐ NO
If your answer to the above question is yes, please complete the following information.

Name of Insured	Insurance Company	Policy Number
Name of Insured	**Insurance Company**	**Policy Number**
Name of Insured	**Insurance Company**	**Policy Number**

Employee's Signature_____**Date**_____

REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service**. I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

_____
Signature

_____
Date

LTD

OFFICE OF PENSIONS

DENTAL INSURANCE COVERAGE

REFUSAL

I elect not to participate in a dental insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.
Form DR (4/2007) §

LTD

Enrollment/Change Form

Please print and complete all sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

EMPLOYER INFORMATION: To be Completed by Employer

Group Number	Employer Name	Effective Date
9812363	State of Delaware	

PENSIONER INFORMATION A: Add (enroll) T: Terminate C: Change (change of name, address or phone)

☐ADD ☐TERM ☐CHG	Gender ☐ M ☐ F	Pensioner ID	Last Name (Pensioner or subscriber)	First Name	M.I.	Date of Birth

Social Security Number	Home Street Address	City/State/Zip	Home Phone ( )

FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (pensioner)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (spouse)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth
☐A ☐T ☐C	Gender ☐ M ☐ F	Last Name (dependent)	First Name	M.I.	Date of Birth

Pensioner Signature: _____ **Date:** _____

Instructions:

Effective date: Beginning date of coverage.
Family Information: List only eligible family members who are enrolling.
Dependent eligibility is the same as employer's health plan.
(A) Add: Open (group) enrollment or new (individual) enrollment during the contract period.
(T) Terminate: To terminate enrollment.
(C) Change: A change of Pensioner name, address or phone

The vision plan is a binding election. Once enrolled, you may not drop coverage during the plan year.

Please note: ***The enrollment form is for the Pension Office's use only and will not be used for any external purpose.***

IMPORTANT: Please see reverse side for authorization of healthcare deductions from the Long-Term Disability benefit.

REQUEST AND AUTHORIZATION FOR DEDUCTIONS
FROM LONG-TERM DISABILITY BENEFIT

I am requesting and authorizing The Hartford to withhold full and/or partial current and/or retroactive health care deductions from my Long Term Disability (LTD) benefit for the purpose of paying health care premiums due for my chosen medical, dental and/or vision care coverage through the State of Delaware. Additionally, I acknowledge 1) that while the State of Delaware will establish the initial priority order of deductions should there be insufficient funds to cover all deductions, I may request a change in the priority order of my deductions by contacting the State of Delaware's Office of Pensions and 2) that the State of Delaware may periodically revise the amount of premium/cost and communicate that revised amount to The Hartford. In such event, I authorize The Hartford to deduct that revised amount from any LTD benefit that may be payable to me. Health care deductions will be forwarded to the State of Delaware's Office of Pensions by The Hartford. **In the event my LTD benefit terminates or is interrupted for any reason, I understand that it is my responsibility to contact the State of Delaware's Office of Pensions at (302) 739-4208 or (800)722-7300 immediately to find out what I need to do to continue the required premium payments for my healthcare coverage(s). I understand and agree that The Hartford assumes no liability and expressly disclaims any and all liability which may result from the termination, cancellation, or interruption of any health care coverage paid through the utilization of The Hartford's Benefit Deduction Service**. I further understand and agree that if the State of Delaware's disability policy with The Hartford should terminate and/or if I return to work in any capacity for the State of Delaware or another employer, my health care deductions will cease to be deducted from my Long Term Disability benefit. Should my benefits be insufficient to cover the deductions, I will be billed by the State of Delaware and will be required to pay the cost of insurance directly to the State of Delaware.

_____
Signature

_____
Date

LTD

OFFICE OF PENSIONS

VISION INSURANCE COVERAGE

REFUSAL

I have been advised of the vision plan provided by EyeMed Vision Care.

I elect not to participate in the vision insurance coverage plan offered through the Office of Pensions.

Name: _____

Employee ID: _____

Signature: _____

Social Security # _____

Date: _____

In most cases, future enrollment opportunities in the plans are restricted to an annual reopening.

Form VR (2/2011) §

LTD

APPLICATION FOR MEMBERSHIP

Blood Bank of Delaware Group Plan

_____ _____ _____ Date: _____
(First) (M.I.) (Last)

Street Address _____

City _____ State _____ Zip _____

Social Security No. (OR Employee ID Number) _____

Telephone (home) _____ Date of Birth _____

(business) _____

Name of Spouse/Civil Union Spouse _____ Social Security No. _____

Your Employer STATE OF DE - RETIREE

I understand that all new members are required to fulfill a blood obligation shortly after joining. I also understand that my group sponsor is not responsible for that obligation.

_____ _____
Date ***Signature***

WAIVER FORM

Blood Bank of Delaware Group Plan

I have reviewed the details of Blood Bank of Delaware's Group Program, and do not wish to become a member at this time.

_____ _____ _____ Date: _____
(First) (M.I.) (Last)

Street Address _____

City _____ State _____ Zip _____

Social Security No. (OR Employee ID Number) _____

Telephone (home) _____ Date of Birth _____

(business) _____

_____ _____
Date ***Signature***

LTD

Spousal Coordination of Benefits Policy Form for Pensioners

State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED **Check Carrier: ☐ Blue Cross ☐ Aetna**

YOUR FULL NAME - Last, First, Middle Initial	YOUR HOME PHONE - Include area code
YOUR SOCIAL SECURITY NUMBER	Are you and your spouse both benefit eligible State of Delaware employees or retirees? ❙ Yes ❙ No

SPOUSE'S FULL NAME - Last, First, Middle Initial	SPOUSE'S SOCIAL SECURITY NUMBER	❙ Male ❙ Female	SPOUSE'S BIRTH DATE / /

SPOUSE INFORMATION

My spouse is:

❙ Not Employed ❙ Employed Full-time ❙ Employed Part-time ❙ Self-employed ❙ Retired
Date of Retirement _____

NAME AND ADDRESS OF SPOUSE'S EMPLOYER OR FORMER EMPLOYER (If spouse is a benefit eligible State of Delaware employee or pensioner, simply write State of Delaware in this box and sign/date form)	SPOUSE'S EMPLOYER/FORMER EMPLOYER PHONE NUMBER (Include Area Code)

Does your spouse's employer or former employer offer health care insurance? ❙ Yes ❙ No	Is your spouse enrolled in health care insurance through this employer or former employer? ❙ Yes ❙ No Is this a Health Savings Account (HSA) plan? ❙ Yes ❙ No	If not enrolled, what percentage of the premium of the lowest benefit employee only/retiree only plan would your spouse be required to pay?* **Flexible benefits and credits apply toward employer's contribution*

If your retired spouse declined health care coverage at retirement, does the former employer permit him or her to enroll at the next enrollment period? ❙ Yes ❙ No	If your spouse is permitted to enroll in retiree health care coverage, what is the date of the next enrollment period?

What is the name of your spouse's health insurance carrier'?	What is your spouse's plan policy number? Effective Date:	Annual plan renewal date for your spouse's employer/former employer health coverage: Month: Day:

Is your spouse enrolled in Medicare: ❙ Yes ❙ No	Is your spouse's health plan a Medicare Supplement plan? ❙ Yes ❙ No
Does your spouse's health plan cover prescription drugs? ❙ Yes ❙ No	If you are completing this form due to your spouse's loss of coverage please indicate the termination date of that coverage. Date:

ADDITIONAL COMMENTS OR EXPLANATION:

STOP! BEFORE SIGNING, PLEASE READ THE AUTHORIZATION SECTION ON THE BACK OF THIS FORM.

YOUR SIGNATURE BELOW VERIFIES THAT YOU HAVE READ AND UNDERSTAND ALL INFORMATION INCLUDED IN THE AUTHORIZATION SECTION.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT AND I HAVE READ THE AUTHORIZATION SECTION:

Pensioner's Signature

Date: / /

Revised SBO 4/1/2012

AUTHORIZATION

Please read carefully the information below before signing. You are responsible for understanding the requirements of the Spousal Coordination of Benefits Policy described here, for providing verification as requested, and for the accuracy of the information in this form.

- I understand that the following policy applies to spouses who regularly work full-time and are eligible for medical coverage through their own employers and spouses who are retired and are eligible for medical coverage through their former employers:
  1. This information will be shared with the State of Delaware's plan administrator(s).
  2. If spouses do not enroll in their own employers' (or former employers') medical coverage, the State will reduce payment to 20% of covered services provided by the employee's State of Delaware benefit plan, and amounts not paid will be the sole responsibility of the employee and spouse.
  3. If spouses enroll in their own employers' medical coverage, those plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
  4. For spouses of active State of Delaware employees who are retired and enrolled in the former employer's coverage, the State of Delaware plan pays first. For spouses of State of Delaware pensioners who are retired and enrolled in the former employer's coverage, the former employer's coverage pays first as described in #3 above.
- I understand that the Coordination of Benefits form must be completed in order to cover my spouse on my State of Delaware Group Health Insurance plan. The form is used to determine a spouse's eligibility to receive primary State of Delaware health benefits. Generally, the following spouses are not required to enroll in their company health benefits and may receive primary State of Delaware health benefits:
  - Spouses not working full time, **or**
  - Spouses who do not yet qualify for coverage through the employer (verification of eligibility date may be required from the employer); **or**
  - Spouses whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available (verification from the company may be required), **or**
  - Spouses whose employer does not offer medical coverage (verification from the employer may be required), **or**
  - Retired spouses whose former employers do not offer medical coverage for retirees (verification from the employer may be required), **or**
  - Retired spouses whose former employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available (verification from the company may be required).
  - Spouses who (1) retired before October 1, 2011, (2) declined medical coverage at the time of retirement, and (3) are now not permitted to enroll during the employer's next Open Enrollment (verification may be required).
- If any of this information changes, I must complete a new form within 30 days.

Please go to www.ben.omb.delaware.gov/documents/cob to read the complete Spousal Coordination of Benefits policy.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, The State of Delaware will verify the accuracy of information by conducting audits, contacting you, and/or contacting your spouse's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your spouse. Any claims that paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

Please sign and return the completed form to the Pension Office.

LTD

Adult Dependent Coordination of Benefits Form

State of Delaware

PLEASE PRINT ALL INFORMATION REQUESTED **Check Carrier: ☐ Blue Cross ☐ Aetna**

EMPLOYEE FULL NAME - Last, First, Middle Initial			YOUR HOME PHONE - Include area code
EMPLOYEE SOCIAL SECURITY NUMBER			Check one: This is the first form for my adult dependent ❙ This is an updated form for my adult dependent ❙
ADULT DEPENDENT'S FULL NAME - Last, First, Middle Initial	ADULT DEPENDENT'S SOCIAL SECURITY NUMBER	❙ Male ❙ Female	DEPENDENT'S BIRTH DATE / /

EMPLOYER INFORMATION

MY ADULT DEPENDENT IS: ❙ Full-time Student ❙ Employed Full-time ❙ Employed Part-time ❙ Not Employed

NAME AND ADDRESS OF EMPLOYER		EMPLOYER PHONE NUMBER Include Area Code
Does this employer offer health care insurance to employees? ❙ Yes ❙ No	Is your adult dependent enrolled in health care insurance through this employer? ❙ Yes ❙ No Is this a High Deductible Plan with a Health Savings Account (HSA)? ❙ Yes ❙ No	If not enrolled, what percentage of the premium of the lowest benefit employee only plan would your adult dependent be required to pay?* **Flexible benefits and credits apply toward employer's contribution*
What is the name of your adult dependent's health care insurance carrier'?	What is the plan policy number? Effective Date:	Annual plan renewal date for this employer: Month: Day:
Does this employer's medical plan cover prescription drugs? ❙ Yes ❙ No	Your additional comments:	
If you are completing this form due to your adult dependent's loss of coverage please indicate the termination date of that coverage.	Date:	

AUTHORIZATION

I understand that the following policy applies to adult dependents age 21 to 26 who are eligible for health care coverage through their own employers:

- This information will be shared with the State of Delaware's plan administrator(s).
- If adult dependents over age 21 take advantage of their own employer's health care coverage, these plans pay their benefits first. Then the State of Delaware will pay additional covered expenses, if any, up to the maximum allowed under our employee's family benefit plan, not exceeding a limit of 100% coverage from both plans combined.
- If adult dependents over age 21 do not take advantage of their own employer's health care coverage, the State will pay 20% of covered services provided by the employee's State of Delaware benefit plan.

I understand this form must also be completed every year during Open Enrollment or any time my adult dependent's employment or coverage situation changes in order to cover my adult dependent under the State of Delaware Group Health Insurance plan. The form is used to determine eligibility to receive primary State of Delaware health benefits. Generally, the following adult dependents over age 21 are not required to enroll in their employers' plans:

- Adult dependents who are full-time students under age 24, or
- Adult dependents who are not working full time, or
- Adult dependents whose employer does not offer health care coverage, or
- Adult dependents whose employers require a contribution of more than 50% of the premium for the lowest benefit employee only plan available.

If any of this information changes, I must complete a new form within 30 days and submit to my agency benefits representative.

Notice to all parties completing this form: To insure benefits are coordinated properly between employers, the State of Delaware will verify the accuracy of information by conducting audits, contacting you, and contacting your adult dependent's employer. It is fraudulent to fill out this form with any information which is false or incorrect or to omit important facts. Providing false or incorrect information may result in disciplinary action and sanctioned payment (reduced to 20%) of claims for your adult dependent. Any claims paid based on false or incorrect information will be reversed and payment will be the responsibility of the employee.

Please return completed form to your organization's Human Resources or Benefits Representative.

I HEREBY CERTIFY THAT THE ABOVE STATEMENTS ARE CORRECT Member's Signature	Date: / /

A complete copy of the State of Delaware's Policy can be found online at **www.ben.omb.delaware.gov/documents/cob**

4/1/2011